ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

Founded in 1977

October 16, 2014

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Amendments to Arkansas Health Care Independence Program ("Private Option") Demonstration

Dear Secretary Burwell:

Arkansas Advocates for Children and Families (AACF) is supportive of the efforts in Arkansas to extend health care coverage to adults earning less than 138% of the federal poverty level through the Health Care Independence Program, also known as Private Option. The Private Option has allowed 205,000 underinsured adults in Arkansas access to health care coverage. An additional 25,000 children have also been enrolled in ArKids as their parents enrolled. Arkansas leads the nation in reducing the number of uninsured adults by cutting the figure in half from 22.5 percent in 2013 to 12.4 percent in midway through 2014.[1]

While AACF supports the continued implementation of the Private Option, the proposed amendments to Arkansas's 1115 waiver should not be approved as submitted because they place undue financial burdens on low income families, and seek to waive several important consumer protections. The comments below reflect our concerns about the following proposed amendments: imposing cost-sharing requirements on beneficiaries earning below 50% FPL, creating health savings accounts or Independence Accounts, and limiting the non-emergency transportation benefit.

Cost-Sharing Requirements

CMS should not approve the proposed amendment to impose new cost-sharing requirements on individuals enrolled in the Private Option. Under the proposed amendment Arkansas would implement, monthly contributions would be required for all individuals earning over 50% FPL. These monthly contributions would be $5 for adults earning 50-99% FPL and $10-25 for individuals with incomes from 100-138% FPL.

[1] Witters, D. (2014) Gallup. *Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate*. Retrieved from: http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx?sf29424162=1.

The proposed monthly contributions should be considered to be premiums and thus prohibited for Medicaid beneficiaries below the poverty line. As a monthly payment that is owed whether or not enrollees utilize care, the monthly contributions should be treated as a "similar charge" to premiums under section 1916(a)(1) of the Social Security Act. To date, no state Medicaid demonstration projects have been approved that require adults in the mandatory group of low-income individuals, in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to pay premiums below the poverty line as proposed in the Arkansas plan. If approved, this would set a new dangerous, precedent that conflicts with Medicaid statute.[2] Premiums have been shown to limit enrollment of eligible people in numerous studies.[3] AACF supports the current Private Option standards that do not require any premiums or deductibles.

The amendment to impose cost-sharing requirements on a broader population does not assist in promoting the goals of the Medicaid statute because it impedes the provision of health coverage to individuals with low incomes. An 1115 demonstration project must be "likely to assist in promoting the objectives" of the Medicaid Act. Charging low-income individuals a premium or other cost-sharing requirements is not an appropriate use of demonstration authority due to existing evidence that premiums reduce enrollment and reduce access to care.[4] Cost-sharing has been shown to lead to significant reductions in the utilization of services, including effective and essential services.

Independence Account Contributions

Arkansas's waiver amendments propose that these monthly contributions be collected through Independence Accounts. These Independence Accounts are structured like health savings accounts and require beneficiaries pay required contributions, while the state will make contributions to ensure funds are sufficient to cover deductibles, co-payments, and coinsurance obligations.

Failure to make monthly contributions will result in financial burdens for enrollees and create access to care barriers. The Arkansas proposed amendments are financially burdensome because they include a requirement that an individual failing to make monthly contributions incur a debt to the state, once the accrued balance in the account is exhausted. Even more financially burdensome requirements are proposed for beneficiaries above 100% FPL. If they fail to make payments, QHP co-payments and coinsurance will be due at the point of service. A large body of research has demonstrated that cost sharing requirements in Medicaid reduce access to care and can lead to poor health outcomes. In Oregon, a similar experiment with cost-sharing resulted in increased medical debts and unaffordable care among Medicaid enrollees.[5]

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[2] Similar comments were submitted by the Center on Budget and Policy Priorities and Georgetown University Center for Children and Families on the Healthy Indiana Plan 2.0 1115 Waiver submission. Indiana's waiver application proposed imposing premiums on people with income below 50% FPL. Comments are available here: http://ccf.georgetown.edu/wp-content/uploads/2014/09/CBPP-and-CCF-HIP-2-0-Comments.pdf.

[3] Kaiser Commission on Medicaid and the Uninsured (2013). *Premiums and Cost-Sharing in Medicaid.* Retrieved from http://www.kff.org/medicaid/8417.cfm.

[4] Strong. (2013). The Facts on Medicaid Copayments: Considerations for Arkansas. Arkansas Advocates for Children and Families.

[5] Ibid. Also see O'Malley and Artiga. (2005) *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences.* Kaiser Commission on Medicaid and the Uninsured.

Independence Account requirements are complicated and will create confusion for beneficiaries. Many of the adults enrolled in Private Option coverage were uninsured, and the concepts related to health savings accounts will be unfamiliar. It is estimated that over 37 percent of adults in Arkansas have low health literacy, which far exceeds the national rate of 12 percent.[6] Additionally, individuals that are uninsured or enrolled in Medicare and Medicaid are more likely to have low health literacy. This may to result in increased access barriers for beneficiaries that are unaware of required contributions and face financial penalties for failing to make payments.

The costs of startup and administration for Independence Accounts could exceed total contributions collected from beneficiaries. Although administrative costs are not included in budget neutrality, DHS has not released figures reflecting the costs associated with operating Independence Accounts and the estimated total monthly contributions to be collected from Private Option enrollees. However, a contract was recently approved for $9.3 million for a third party vendor to administer HSAs for Private Option enrollees. Indiana implemented a similar program through the Health Indianan Plan (HIP) in 2008 and recently submitted an 1115 demonstration application proposal for HIP 2.0. Indiana's HIP features health savings accounts called POWER accounts and enrollees make monthly payments, along with state and federal contributions, to cover their deductible.[7] The HIP 2.0 proposal cites research demonstrating some savings to the state.[8] Yet, a recent analysis of literature shows mixed results regarding costs and savings, particularly from health reimbursement arrangements (HRAs) and HSAs.[9] Even without administering individual accounts, collection costs and monitoring out-of-pocket caps may exceed the value of premiums collected, calling into question the logic of charging small monthly amounts. For example, Virginia imposed a $15 per child per month premium on families with income between 150-200 percent of the FPL. The state permanently eliminated premiums when a study indicated that the state was spending $1.39 in administrative cost to collect every $1 in premium.[10] As a result, it is unclear if implementing HSAs would negatively impact Arkansas's ability to promote cost-effective use of the health care system through HSAs, as required in the approved 1115 waiver. This may also threaten the sustainability of the Private Option and put beneficiaries at risk of losing affordable coverage.

Non-Emergency Transportation

Access to non-emergency transportation is an important benefit for beneficiaries enrolled in the Private Option. Lack of transportation has been shown to reduce utilization of health care services among low-

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[6] Arkansas Department of Health (2013). *Arkansas's Big Health Problems and How We Plan to Solve Them*. Retrieved from http://www.healthy.arkansas.gov/aboutADH/Documents/Accred/ARHealthReportHealthProblems.pdf.

[7] Kaiser Family Foundation (2008). *Summary of Healthy Indiana Plan: key facts and issues*. Retrieved from http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7786.pdf.

[8] Medicaid.gv. Healthy Indiana Plan 2.0 1115 Waiver Application. Retrieved from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2.0/in-healthy-indiana-plan-support-20-pa.pdf.

[9] Bundorf. K. Robert Wood Johnson Foundation (2012). *Consumer-Directed Health Plans: Do They Deliver*? Retrieved from http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf402405. See also National Health Law Program. NHLP Comments on Healthy Indiana Plan 2.0 ad Healthy Indiana Plan Retrieved from http://www.healthlaw.org/component/jsfsubmit/showAttachment?tmpl=raw&id=00Pd000000E5pcMEAR.

[10] Tricia Brooks (2013). *Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters.* Retrieved from http://ccf.georgetown.edu/ccf-resources/handle-with-care-how-premiums-are-administered-in-medicaid-chip-and-the-marketplace-matters/

income people.[11] The Private Option must ensure access to care for enrollees, including those who need assistance with transportation. **HHS should not waive Arkansas's obligation to provide non-emergency transportation unless the state's proposal clearly articulates the process for those who need the benefit to obtain all the transportation services they need.** While the proposal promises an extension of the limited transportation benefit will be available, it does not provide sufficient details on how beneficiaries will qualify for or access this extension. Furthermore, the process of informing beneficiaries of the change in benefits, the availability of extended benefits, and how to access them should be described in detail.

Conclusion

AACF is proud of the progress in Arkansas to extend coverage to uninsured adults, and we think it is vitally important to prevent future changes to the program that place these gains in coverage and health care access at risk. As the program evolves, it is critical that it continues to be a pathway to coverage for low-income adults in Arkansas.

Thank you for the opportunity to submit comments on the amendments to the Arkansas Health Care Independence Program demonstration. Please contact us at Arkansas Advocates for Children and Families for more information.

Respectfully,

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[11] Shoup. (2011). The Leadership Conference Education Fund. The Road to Health Care Parity: *Transportation Policy and Access to Health Care*. Retrieved from http://civilrightsdocs.info/pdf/docs/transportation/The-Road-to-Health-Care-Parity.pdf.